

Case Number:	CM13-0031904		
Date Assigned:	01/10/2014	Date of Injury:	06/17/2008
Decision Date:	03/20/2014	UR Denial Date:	09/13/2013
Priority:	Standard	Application Received:	10/04/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The applicant is a represented [REDACTED] employee who has filed a claim for chronic neck and shoulder pain reportedly associated with an industrial injury of June 17, 2008. Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation; transfer of care to and from various providers in various specialties; and topical agents. In a utilization review report of September 13, 2013, the Claims Administrator denied a request for an MRI of the cervical spine, denied a request for an MRI of the left shoulder, denied electrodiagnostic testing, denied medications, and approved a followup visit. Non-MTUS-ODG Guidelines were cited, although the MTUS does address several of the topics at hand. The applicant's attorney subsequently appealed. An earlier note of August 19, 2013 is notable for comments that the applicant reports persistent left upper extremity and left shoulder pain, 6-9/10. The applicant has numbness radiating down the left upper extremity to the little finger of the left hand. The applicant's pain has grown progressively worse. The applicant is reportedly working despite having severe pain complaints. The applicant has a history of previous left upper extremity peripheral neuropathy established on earlier electrodiagnostic testing performed through a qualified medical evaluator in December 2008. 5/5 strength is noted about the upper and lower extremities. The applicant's shoulder range of motion is within normal limits. Reduced sensation is noted about the upper extremities. MRI of the cervical spine, MRI of the left shoulder, cervical epidural steroid injection, electrodiagnostic testing, tramadol, and Voltaren gel are renewed. It is stated that the applicant may be considering cervical epidural steroid injection therapy. He has returned to regular work. An earlier note of March 12, 2013 is also notable for comments that the applicant is continuing to work despite ongoing pain complaints.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Magnetic Resonance Imaging (MRI) of the cervical spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 8, Table 8-8, page 182, MRI or CT scanning is "recommended" to validate a diagnosis of nerve root compromise, based on clear history and physical exam findings, in preparation for an invasive procedure. In this case, the employee has persistent complaints of cervical spine pain radiating to the left upper extremity. There is evidence of altered sensorium/dysesthesias present about the left hand. The applicant is apparently contemplating an interventional pain procedure, an epidural steroid injection. MRI imaging to clearly determine the source of the employee's radicular complaints is therefore indicated. Accordingly, the original utilization review decision is overturned. The request is certified.

Magnetic Resonance Imaging (MRI) of the left shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 208, 214.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 9, page 208, imaging may "be indicated" to clarify the diagnosis and assist reconditioning in those applicants who have persistent limitations of activity after four weeks with unexplained physical findings. In this case, the employee has had symptoms and associated limitations which have persisted for a protracted amount of time. The source of the employee's complaints has not been clearly identified. The employee is reportedly having severe pain while lying on the shoulder at night. MRI imaging to clearly delineate the source of the employee's shoulder pathology is indicated and appropriate. Therefore, the request is certified, on independent medical review.

EMG/NCS of the left upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 8, Table 8-8, EMG testing for the diagnosis of nerve root involvement is "not recommended" when findings of history, physical exam, imaging study are consistent. In this case, MRI imaging to clearly delineate the source of the employee's cervical spine pathology has been certified, above. It will be more appropriate to determine the results of the same before electrodiagnostic testing is sought, as suggested by ACOEM. Therefore, the request is not certified, on independent medical review.

Ultram 50mg, #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section When to Continue Opioids Page(s): 80.

Decision rationale: As noted on page 80 of the MTUS Chronic Pain Medical Treatment Guidelines, the cardinal criteria for continuation of opioid therapy include evidences of successful return to work, improved functioning, and/or reduced pain effected as a result of ongoing opioid usage. In this case, the employee has responded favorably to prior introduction of tramadol, an opioid analogue. The employee has reportedly returned to work. The employee is apparently performing arduous physical work at a rate of 40 hours a week. The attending provider has written that the employee's usage of pain medication is diminishing his pain levels. The MTUS criteria for continuation of tramadol have seemingly been met. Therefore, the request is certified.

Voltaren 1%, #5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

Decision rationale: As noted on page 112 of the MTUS Chronic Pain Medical Treatment Guidelines, Voltaren gel is indicated for the relief of arthritic pain in joints which lend themselves toward topical applications, such as ankle, elbow, foot, hand, knee, and/or wrist. Voltaren has not been evaluated for treatment of the spine or shoulder. In this case, the employee is alleging cervical spine and left shoulder pain. Voltaren gel has not, according to the MTUS Chronic Pain Medical Treatment Guidelines, been evaluated in treatment of the same. The employee's successful usage of oral pharmaceuticals such as Naprosyn and tramadol, moreover, effectively obviates the need for the Voltaren gel. Therefore, the request is not certified, on independent medical review.

Referral to Neurologist for EMG/NCS left upper extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Office Visit.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

Decision rationale: Again, as noted in the MTUS-adopted ACOEM Guidelines in Chapter 8, Table 8-8, EMG testing for the diagnosis of nerve root involvement is "not recommended" when findings of history, physical exam, and imaging study are consistent. In this case, MRI imaging to clearly delineate the source of the employee's cervical spine complaint has been certified, above. The employee's history and physical findings are, moreover, seemingly consistently with a suspected diagnosis of cervical radiculopathy. EMG testing is not indicated, for all the stated reasons, as it would be more appropriate for the employee to await the results of the cervical MRI before EMG testing is sought. Therefore, the request is likewise not certified, on independent medical review.